ANMED HEALTH
We're in this together.

# Coverage Assistance & Financial Assistance

## CAFA Overview

The information collected in this application is required in order to determine eligibility for Coverage Assistance and Financial Assistance (CAFA). CAFA is a financial assistance program for uninsured patients who have received services with AnMed Hospital and/or AnMed Physician Services. Eligibility is based on a patient's household income as compared to federal poverty guidelines.

**Requirements to Apply for CAFA**

- The patient must be uninsured.
- The patient must reside in South Carolina or Georgia.
- The patient must fully cooperate with determination of other coverage options including but not limited to Medicaid, Cobra, Workman's Compensation, Liability, etc. If additional information and/or proof of income, bank statements, etc. is requested, a letter will be mailed to the patient to let them know what is needed and the deadline to submit. If the information is not received by the deadline, the patient will not be eligible for CAFA.
- The patient must complete the CAFA application in its entirety.

**Documents required to accompany the CAFA Application**

*Please send only copies as these will not be returned.*

- Proof of last month's household income: Check stubs, unemployment letter, Award Letter from SSA.
- Bank statements for the last two months (checking and/or savings) for all bank accounts patient and spouse are listed on.
- If legally separated from your spouse, please provide proof of the legal separation.

**Patient Information**

| Patient Name | Social Security Number | Date of Birth | Account # |
|---|---|---|---|
| | | | |

| Mailing Address | City | State/Zip |
|---|---|---|
| | | |

| Street Address if different than above | City | State/Zip |
|---|---|---|
| | | |

| County you reside | Place of Birth | Legal resident/citizen : Yes or No | Lived in US since |
|---|---|---|---|
| | | | |

| Mother's Maiden Name | Phone | Email |
|---|---|---|
| | | |

**LIST ALL HOUSEHOLD MEMBERS**

| Name | Date of Birth | SSN | Relationship to Patient | Sex/Race |
|---|---|---|---|---|
| | | _ _ | | |
| | | _ _ | | |
| | | _ _ | | |
| | | _ _ | | |
| | | _ _ | | |
| | | _ _ | | |

If additional space is needed please use the notes section of this application.

| Current Employment | Pay Rate Hr/Wk | Job title | Date of Employment |
|---|---|---|---|
| Spouse's Employment | Pay Rate Hr/Wk | Job title | Date of Employment |

**If there is no household income, please have the person supporting you to complete this section.**

This is to certify that I am/was providing the following type of support and assistance to the above named applicant: ☐ Food ☐ Shelter ☐ Cash Amount per month: $_____
I am not responsible, nor able to pay for any hospital or medical expenses for him/her.

Signature _____ Phone Number _____ Date _____

Address if different from above: _____ City _____ State _____ Zip _____

| | | | | |
|---|---|---|---|---|
| Has a member of the household lost their job within the last 60 days? | Check one | ☐ YES | ☐ NO | |
| Did he/she receive a COBRA election Notice? | Check one | ☐ YES | ☐ NO | |
| Did he/she elect COBRA coverage? | Check one | ☐ YES | ☐ NO | |
| Have you or do you plan to apply for disability with Social Security Administration? | Check one | ☐ YES Date _____ | ☐ NO | |
| Are you pregnant? ☐ YES ☐ NO | Were you in foster care in SC at the age 18 or older? | ☐ YES | ☐ NO | |

## Monthly Household Income

| Type of income | Monthly Gross Income for Applicant | Monthly Gross Income for Spouse |
|---|---|---|
| Employment Income | $ | $ |
| Retirement/Pension | $ | $ |
| Social Security Retirement | $ | $ |
| Social Security Disability Income | $ | $ |
| Unemployment Income | $ | $ |
| Child Support | $ | $ |
| Alimony | $ | $ |
| Other (list source here _____) | $ | $ |

## Acknowledgement and Signatures

I hereby certify the information provided in this CAFA application is true, accurate and complete to the best of my knowledge. I hereby authorize AnMed to contact any person, firm, or organization to verify any of the information given and I hereby authorize any such person, firm, or organization to release to AnMed any financial information it may request. If the hospital believes that I may be eligible for coverage, I agree to cooperate with the facility's efforts in obtaining benefits.

Applicant Signature Date

## Notes

**How to submit application: Hand deliver to:** **AnMed Business Office**
**522 North McDuffie Street**
**Anderson, SC 29621**

**Mail to:** **AnMed Health**
**Attention: Financial Counselors**
**800 North Fant Street**
**Anderson, SC 29621**

Anderson County
South Carolina

APPOINTMENT OF PERSONAL REPRESENTATIVE AND
AUTHORIZATION FOR RELEASE OF INFORMATION

This is to certify that I, the undersigned, have applied or wish to apply for Medical Assistance benefits for and on behalf of myself or (Patient): _____ I hereby appoint Financial Counselor(s): _____ or his or her successor on the Financial Counseling staff of AnMed Health, as my agent and personal representative and as the agent and personal representative of the Patient for the purpose of initiating applications for such benefits and/or conducting any and all activities associated with determining eligibility for such benefits, including, if required, the initiation and conduct of administrative and/or judicial appeals procedures concerning eligibility for such benefits. I also authorize the Hospital to use its own personnel and, at its own expense, to obtain legal consultation and representation to evaluate and pursue activities related to a determination of my or the Patient's entitlement to Medical Assistance benefits. This appointment and authorization shall also be valid for purposes of the AnMed Medical Assistance Fund ("AMAP") and any Hospital charity program for which I or the Patient may apply.

Furthermore, I hereby request and authorize the appropriate County Department of Social Services where any such application is to be made or is pending, and the South Carolina Department of Health and Human Services to accept this appointment of my personal representative and agent with respect to any application for such benefits and to accept from and release to said personal representative or counsel (or other representative of the Financial Counseling staff of AnMed Health) any and all information related in any way to any application and determination of eligibility for such benefits. I specifically request that copies of all notices about or requests for information related to eligibility for such benefits be provided to my personal representative at (864) 512-3435 or by mail addressed to the attention of such personal representative at Office of Financial Counseling, AnMed Health, Anderson, SC.

Furthermore, I hereby authorize and direct any other person, firm, corporation, government agency, or other entity (specifically including but not limited to the Social Security Administration, all physicians, hospitals, banks, credit unions and insurance companies) who has or may have information from records or services rendered prior or subsequent to the execution of this authorization (specifically including but not limited to my identifiable health information concerning medical treatment and/or health status, insurance coverage of any type, eligibility for any benefits under the Federal Social Security Act, or financial information of any type) that is or may be relevant to the determination of eligibility for such benefits to release such information to the said personal representative as he or she may request. I UNDERSTAND THAT INFORMATION TO BE RELEASED MAY INCLUDE INFORMATION REGARDING DRUG OR ALCOHOL ABUSE, SICKLE CELL ANEMIA, PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AIDS RELATED COMPLEX (ARC), HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND/OR GENE-RELATED IMPAIRMENT OR GENETIC TESTING RESULTS.

This consent may be revoked by me at any time by written notice to the Financial Counselor at the address shown above, except to the extent that action has already been taken in reliance on this consent. Unless so revoked, this consent shall be valid for the longer of three hundred sixty-five (365) days from the date indicated below, or until my Medicaid eligibility is finally determined and the time for appeals has lapsed. I specifically waive any lesser time periods or restrictions required by any entity from whom information is requested as set out above.

The purpose of disclosure is to review these materials in connection with Medicaid, AMAP, or other health benefit eligibility and/or coverage. The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary.

I further request that a photocopy or telefacsimile of this signed appointment and authorization be accepted and honored as if it were an original. This appointment of personal representative is made pursuant to applicable state and federal law including but not limited to 42 C.F.R. §431.200 et seq., 42 C.F.R. §435.907 and §435.908, S.C. Code Regs. §§ 114-410, 126-380, and South Carolina Medicaid Manual §1.02.02.

Date: _____ Signature _____

_____ _____
Witness Typed or Printed Name

_____
Witness
**(Witnesses (2) required if signature is by mark.)**

Healthy Connections MEDICAID

# Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

| Name of Medicaid applicant/member | Social Security Number |
|---|---|
| | |

## Appointing an Authorized Representative

**Would you like to allow someone to represent you on all matters related to your case?**

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an "authorized representative." The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

Name of Authorized Representative (First name, Middle name, Last name)

Financial Counselor AnMed Health

☑ New ☐ Change ☐ Addition

☐ Remove this person or organization as my authorized representative

| Authorized Representative's address (Leave blank if you don't have one.) | Apartment or suite number |
|---|---|
| 800 N Fant Street | Admitting Department |

| City | State | ZIP code |
|---|---|---|
| Anderson | SC | 29621 |

| Authorized Representative's phone number | Other phone number |
|---|---|
| 864-512-3435 | 864-512-1450 |

Authorized Representative's email address

financialcounselor@anmedhealth.org

| Organization name (if applicable) | Unit* (if applicable) | ID number (if applicable) |
|---|---|---|
| AnMed Health Hospital | | 1295755536 |

*It is best to identify a specific unit for large organizations.

**OR**

## Permission to Release Information

**Is there anyone that you would like us to share information with about your application?**

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

| Name of person/organization | Phone |
|---|---|
| xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | xxxxxxxxxxxxxxxxxxxxx |

| Address | City | State | ZIP |
|---|---|---|---|
| xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | xxxxxxxxxxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx |

| Unit (if applicable) | ID Number (if applicable) |
|---|---|
| xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx |

| Medicaid applicant/member's signature | Date (mm/dd/yyyy) |
|---|---|
| | |

If signing with an "X," please have two people sign below as witnesses.

Witness: _____ Witness: _____

☐ Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member's inability to sign. Provide reason:

**Mail your signed form to:** SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 **Fax:** (888) 820-1204

**NEED HELP WITH YOUR APPLICATION?** Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

South Carolina Department of Health and Human Services

# INFORMATION RELEASE FORM

I hereby authorize the South Carolina Department of Health and Human Services to verify my income including but not limited to Social Security, Supplemental Security Income, Veterans Benefits, private pensions, earned income, etc.; my resources including but not limited to checking and savings accounts, certificates of deposit, individual retirement accounts, credit union accounts, etc.; insurance, medical history, and expenses; and any other facts relevant to my eligibility for participation in programs administered by the Department of Health and Human Services.

I also authorize any person, partnership, corporation, association, or governmental agency possessing information on such matters to release such information to the Department of Health and Human Services.

I certify that I have read the above statement and understand that this gives my permission for release of such information.

Print your name: _____

Signature: _____

Address: _____

Witnesses to Signature (if signed by an X): 1. _____

2. _____

South Carolina Department of Health and Human Services (SCDHHS)
Eligibility, Enrollment and Member Services
Toll-free (888) 549-0820 TTY (888) 842-3620

# Authorization to Disclose Health Information

| *For Office Use Only* – TO BE COMPLETED BY SCDHHS | | | |
|---|---|---|---|
| **Applicant/Beneficiary Name** *(First)* | *(Middle)* | *(Last)* | |
| **Social Security No.** | **Date of Birth** | **Household No./App ID** | |

**** PLEASE READ BOTH PAGES OF THIS FORM BEFORE SIGNING BELOW.****

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) of:

**WHAT:** *All my medical records, education records and other information related to my ability to perform tasks. This includes specific permission to release the following:*

1. All records and other information regarding my treatment, hospitalization, and outpatient care for any impairment(s) including, but not limited to:
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human Immunodeficiency Virus (HIV) infection, including Acquired ImmunoDeficiency Syndrome (AIDS) or tests for HIV or sexually-transmitted diseases
   - Gene-related impairments, including genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work
3. Copies of education tests or evaluation, including individualized educational programs, triennial assessments, psychological and speech evaluations, teacher observations and evaluations, and any other records that can help evaluate function
4. Information created within 12 months after the date this authorization is signed, as well as past information.

**FROM WHOM:**
- **All** medical sources (hospitals, clinics, labs, physicians, psychologists, etc.), including mental health, correctional, and addiction treatment and VA health care facilities
- All educational sources (schools, teacher records, administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

**THIS BOX TO BE COMPLETED BY SCDVR** (as needed) for additional information to identify the subject (e.g., other names used), the specific source, or the material to be used.

_____

_____

_____

_____

**TO WHOM:** The State agency authorized to process my case (usually called "SCVRD") including contract copy services, doctors, or other professionals consulted during the disability determination process.

**PURPOSE:** I agree to the disclosure of my health information to determine if I meet the disability criteria in order to establish my eligibility for Medicaid benefits

**EXPIRES WHEN: This authorization is binding for 12 months from the date signed below.**

**I UNDERSTAND THAT:**
- I may write to The South Carolina Department of Health and Human Services to revoke this authorization at any time.
- There are some circumstances where the information may be re-disclosed to other parties involved with the Medicaid eligibility determination.
- I may receive a copy of this form upon request.
- I may ask the source to allow me to inspect or get a copy of the material to be disclosed.

| **Applicant Signature (Person Applying for Benefits OR Parent/Guardian if Applicant is Under Age 18):** | **Relationship to Applicant:** |
|---|---|
| **Legal Representative Signature (if Applicant is Unable to Sign Due to Health):** | **Date:** |
| **Child Signature (Required if Applicant is Age 12 to 18):** | ☐ **Power of Attorney or legal guardian documentation is attached if signed by a Legal Representative.** |
| **Witness:** | **Witness if signed with an "X":** |

Social Security Administration

# Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

**TO: Social Security Administration**

| *My Full Name | *My Date of Birth (MM/DD/YYYY) | *My Social Security Number |
|---|---|---|
| | | |

I authorize the Social Security Administration to release information or records about me to:

| *NAME OF PERSON OR ORGANIZATION: | *ADDRESS OF PERSON OR ORGANIZATION: |
|---|---|
| FINANCIAL COUNSELOR FOR | 800 NORTH FANT STREET |
| ANMED HEALTH | ADMITTING DEPT |
| | ANDERSON SC 29621 |

***I want this information released because:** ANMED HEALTH IS ASSISTING WITH MY DISABILITY PROCESS

We may charge a fee to release information for non-program purposes.

PLEASE DISCLOSE MY INFORMATION TO ANMED HOSPITAL ON AN ONGOING BASIS.

INTEND FOR THIS RELEASE FORM TO BE VALID FOR AN INDEFINITE PERIOD OF TIME.

***Please release the following information selected from the list below:**
**Check at least one box. We will not disclose records unless you include date ranges where applicable.**

1. [X] Verification of Social Security Number
2. [X] Current monthly Social Security benefit amount
3. [X] Current monthly Supplemental Security Income payment amount
4. [X] My benefit or payment amounts from date _____ to date _____
5. [X] My Medicare entitlement from date _____ to date _____
6. [X] Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. [X] Complete medical records from my claims folder(s)
8. [X] Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

**I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.**

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

**Relationship (if not the subject of the record):** _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

| 1.Signature of witness | 2.Signature of witness |
|---|---|
| Address(Number and street,City,State, and Zip Code) | Address(Number and street,City,State, and Zip Code) |